STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155684	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFIELD VILLAGE	6450 MIAMI CIRCLE SOUTH BEND, IN46614

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F0000	This visit was for the investigation of Complaint # IN00093132. This visit resulted in a Partially Extended Survey-Immediate Jeopardy. Complaint # IN00093132-Substantiated, Federal/State deficiencies related to the allegations are cited at F-223, F-225, F-226, and F-490. Survey dates: July 11, 12, and 13, 2011 Extended survey dates: July 14 and 15, 2011 Facility number: 002662 Provider number: 155684 AIM number: 200315930 Survey team: Toni Krakowski, RN Census bed type: SNF: 18 NF: 15 NCC: 27 Total: 60 Census payor type: Medicare: 18 Medicaid: 15 Other: 27 Total: 60	F0000	This plan of correction is submitted as required by law. It is not an admission of noncompliance; rather, it serves as the facility's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 4 Supplemental sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/20/11 Cathy Emswiller RN			
F0223 SS=K	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observations, interviews and record reviews, the facility failed to protect residents from physical and verbal abuse by facility staff which resulted in psychological harm and mental anguish as evidenced by residents' fear to summon staff for assistance or provision of their care for 3 of 4 residents (Residents: #B, #C, #D) reviewed for abuse in a sample of 4 and 2 of 6 residents (Residents: #F, #G) in the supplemental sample of 6. The immediate jeopardy began on 7/05/11 when Resident # F, who was recovering from recent back surgery, reported to	F0223	**F 223** Regarding Resident #B, CNA #8 was suspended on 5/4/11 after the facility became aware of the allegation. The CNA was terminated on 5/9/2011 following an investigation into the matter. This incident was reported to ISDH on 5/3/11. Regarding Resident #C, CNA #18 was terminated on 3/17/11, following an investigation into this allegation. This incident was reported to ISDH on 3/14/11. Regarding Resident #D, the facility has reviewed all grievances from this	07/18/2011

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	CNA #3 on 7/4/11 that CNA #2 had thrown her into bed and left her sideways in the bed. Resident # F then reported the incident on 7/5/11 to the Director of Nursing who failed to suspend CNA #2 and protect other residents from potential harm during investigation of the alleged abuse. The Administrator and the Director of Nursing (DON) were notified of the immediate jeopardy at 5:30 P.M. on 7/13/11. The immediate jeopardy was: removed on 7/15/11, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Residents: #B, #C, #D, #F, #G Findings include: 1. Review of a facility "Incident Report," dated 5/3/11, indicated, "...(Resident #B) alleges that on Monday, 5-2-11, a CNA who gave her a shower treated her roughly and had a "bad attitude." She reported that she was sprayed in the face with the shower sprayer...." A"Resident/Family Concern Report," dated 5/3/11, and signed by the Chaplain, indicated, "Nature of Concern: Resident (#B) reported rough handling and bad attitude of CNA #8 when resident asked		resident and/or family members and the facility alleges that this allegation was never reported to any member of administration at this facility. Resident #D has since been discharged from the facility. Because the facility was not aware of these allegations during her admission, an investigation into this alleged incident did not occur. Regarding Resident #F, the resident did not report to the facility that she had been thrown into bed. This allegation was not revealed to administration until the ISDH complaint surveyor interviewed the resident. As soon as the facility became aware of this allegation, CNA #2 was immediately suspended and an investigation was started. CNA #2 was terminated on 7/19/11. The surveyor was aware of this incident during the survey, and a follow-up report was sent to ISDH informing them of the facility's conclusion to the investigation on 7/19/11. Regarding Resident #G, CNA #8 was terminated on 5/9/11 and CNA #15 was terminated on 7/12/11. Mandatory in-services began immediately upon the facility becoming aware of the immediate jeopardy citation on 7/13/11. All staff members were educated before the beginning of their next shift on: the proper protocol to report abuse,	

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	repeatedly for bed pan last week. Resident #B thought she had asked 'someone in charge' to not have this CNA (#8) help with her care. Last evening, 5/2/11, (CNA #8) came to do (Resident #B's) shower. (Resident #8) reported she was sprayed in the face, and (CNA #8) was not following her wishes concerning (Resident #B's) clothing...." During interview with the DON on 7/12/11 at 2:30 P.M., she indicated she was unaware Resident #B requested CNA #8 not be assigned to provide her care. An "Investigation" report, dated 5/4/11 and signed by RN #9, indicated, "On Monday, May 2nd, approx (approximately) 9:00 P.M., I entered (Resident #B's) (room number) with her H.S. (bedtime) meds (medications). (CNA #8) had just showered her. (Resident #B) said to me: 'I don't know what is wrong with that girl. I don't like the way she handles me. When I saw her face I knew I was in for it'...The previous week Nurse (LPN #10) had called (Name), DON re: (regarding) a conflict between (Resident #B) and (CNA #8). (Resident #B) did not want (CNA #8) in her room. I was working Wing 200 that nite (sic) and overheard the phone conversation at the nurses station on Wed., April 27th."		what types of things to report, and what to do if the report is not followed up on. Staff members were instructed to notify the Administrator, or designee in the Administrator's absence, immediately upon becoming aware of any abuse allegation. In-services for all staff were completed by 7/18/11. (Attachment A) Management and on-call nursing staff were in-serviced on 7/14/11 to review proper protocol for reporting abuse. (Included in Attachment A) The facility Administrator reviewed the facility's policies and procedures regarding abuse and neglect on 7/13/11. They were found to be reasonable and accurate. However, after further review, minor modifications were made to the policy, "Abuse- Identification of and Protection of the Resident" to simplify the language and the procedure for staff members. (Attachment B) The facility Medical Director was notified of the immediate jeopardy citation on 7/14/11. The phone numbers of the Administrator and Director of Nursing were posted in multiple locations on 7/14/11 in order for any staff member to directly notify administration of any allegations of abuse, at any time.	

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	Review of the "CNA Evening Assignment," dated 5/2/11, indicated CNA #8 had been assigned to (Resident #B's) room. Review of CNA's Employee Record on 7/11/11 at 3:20 P.M. lacked documentation of an investigation, counseling, or disciplinary action regarding the issue reported by LPN #10 regarding Resident #B's accusation of alleged rough handling by CNA #8 when assisting her with the bedpan (4/27/11). An "Employee Counseling Form," dated 5/3/11, indicated CNA #8 was suspended 5/3/11 pending investigation. The DON indicated in the interview on 7/12/11 at 2:30 P.M. that CNA #8 had been terminated on 5/9/11. Resident #B's closed clinical record was reviewed on 7/11/11 at 3:45 P.M., and indicated diagnoses of, but not limited to, congestive heart failure, hypertension (high blood pressure), and severe osteoporosis (abnormal loss of bone density). An initial MDS (Minimum Data Set) Assessment, dated 4/15/11, indicated she was moderately cognitively impaired with a score of 12 out of 15. 2. Resident #C's clinical record was		The form used as a guide for discussion in daily stand-up meeting was revised on 7/14/11 to include the statement, “Allegations of abuse or neglect?” (Attachment C) In order to ensure all staff are educated on abuse and neglect on an ongoing basis, the facility will continue to provide education on this subject upon hire and at least twice annually. In order to monitor and ensure that abuse policies are followed, the Administrator or her designee, will randomly interview five residents per week for a time period of no less than six months as to how staff members have been treating them. Any concerns will be thoroughly investigated. (Attachment D) Results of the monitoring program will be reviewed at the monthly CQI (Continuous Quality Improvement) meeting. Areas of non-compliance will be addressed immediately. Alleged date of compliance is 7/18/2011.	

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	reviewed on 7/11/11 at 11:55 P.M. and indicated diagnoses of, but not limited to, osteoporosis, rheumatoid arthritis, and fractured left femur (thigh bone). Resident #C's initial MDS (minimum Data Set) Assessment, dated 3/17/11, indicated she was cognitively intact with a score of 15 out of 15. Review of an "Incident Report," dated 3/14/11, indicated, "...(Resident #C) told this writer today at 3:00 P.M. about a problem that she had on Saturday, 3/12/11. She states that (CNA #18) on Saturday 'went all crazy. She started pulling my bed and moving stuff around. She was loud and had me so upset I couldn't half talk. She was swinging my leg around so fast.' I asked if anyone had hurt her or yelled at her. She said no, but she was scared...." A "Resident Statement," dated 3/14/11, was the result of a conversation with the DON and indicated, "...You know I don't know what she (CNA #18) went crazy about. The other lady (CNA #2) looked like she was scared of her. She was movin stuff around, the bed was facing the closet. I said, 'I can't have that way.' She had me so upset I couldn't half talk. Someway I got to the phone and called my daughter...She (CNA #18) was swinging my leg around so fast, too...I been having			

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	so much pain in that leg...." During interview with Resident #C on 7/12/11 at 9:20 A.M., she indicated, "I needed to go to the bathroom. Two CNA's came in to assist me when the one girl (CNA #18) went crazy because she needed more room to get me on the commode (bedside). I was so frightened I couldn't talk and I was having trouble breathing. A third girl came into the room. At one point, they all went into my bathroom and closed the door. I don't know what they were talking about in there. When they got me back into bed, I was facing the wall. I didn't want to face the wall, I wanted to be able to see out my window. The one girl (CNA #18) was slamming things around and shouting. I didn't know what she was going to do next. I was so scared of her. I managed to call my daughter to tell her, but it so happened my son was coming to visit. He said he could hear me calling for help all the way down the hall." During a telephone interview with CNA #2, the other CNA in the room, at the time of the incident, indicated CNA #18 was assigned to Resident #C on the day of the incident, but she (CNA #2) took care of her all day "because I knew how (CNA # 18) could be. I knew (CNA #18) was a very forward type of person and that back			

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	section was very heavy and she's (CNA #18) kinda bossy." She further indicated they told Resident #C they would have to move the furniture around and she was fine with that "do what ever you need to do." "Resident #C threw her arms up in the air almost like she was praying. I asked her if she needed her oxygen because of the way she was acting." When queried if CNA #18 acted appropriately, CNA #2 stated, "I felt that she did everything excessively. She should have explained things first. (CNA #18) was not abusive in any way (but) she was almost like a drill sergeant. Some residents thought she was a man." The DON indicated in an interview on 7/11/11 at 1:30 P.M., she didn't feel she could substantiate that abuse took place, but felt since she had other issues with both of the CNA's (#2 and #18) "It warranted termination." 3. The closed clinical record of Resident #D was reviewed on 7/12/11 at 10:45 A.M. and indicated diagnoses of, but not limited to, vertebral compression fracture, macular degeneration (progressive deterioration in the eye which leads to blindness), peripheral vascular disease (restricted blood flow), fractured left hip, and spinal stenosis (narrowing of the vertebrae). Resident #D's initial MDS			

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	(Minimum Data Set) Assessment, dated 5/18/11, indicated she was cognitively intact with a score of 15 out of 15. During interview with Resident #D's daughter on 7/11/11 at 2:15 P.M., she indicated her mother had told her that a night CNA cussed at her, threw her in bed, and told her "I'm tired of you using that d--n call light. I'm tired of coming into your room. "My mother complained 'They're mean to me. They're mean to me.' I, at first, thought my mother was imagining it, but when the bruises and tremors were evident, I went to the DON with my concerns. I told her mother described the CNA as being (race stated), tall woman. The DON said, 'We don't have a tall (race stated) girl working here.' My mother was lying in bed and looking up at the individual which probably made her look tall." In a second interview with Resident #D's daughter on 7/12/11 at 9:20 A.M., she indicated she asked her mother if she could remember the name of the CNA who was rough with her. "It was a (race stated) girl in the middle of the night." "She did complain to the DON (Name) about the treatment. We were very upset when the bruises were discovered at the hospital. Mother remembers them shoving her around and slamming her into bed and			

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she told them, 'Be careful your going to break my hip, again.' "

During interview with the DON on 7/12/11 at 10:35 A.M., she indicated she was able to validate with the resident that the CNA was just hurrying. She further indicated, as a result, she did not feel there was a need to do a State Reportable.

The Nursing staff schedule was reviewed and indicated CNA #15 was the only (race stated) CNA who provided care to Resident #D on the night shift. The May and June, 2011 schedules indicated CNA #15 was assigned to provide care to Resident #D on the following dates: 5/24, 5/31, 6/7, 6/14, 6/18, and 6/19/11.

During interview with CNA #14 on 5/13/11 at 5:50 A.M., she indicated residents frequently complained to her about a particular CNA refusing to toilet a resident. "I overheard (CNA #15) being rude to a resident. I heard her tell the resident, 'I can't take you to the bathroom again. You just went 10 minutes ago.' Three or four of us girls have gone to the nurse's, but nothing seems to be done about it."

LPN #16 indicated in an interview on 5/13/11 at 5:45 A.M., "One night (CNA #15) came to me and told me she was

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	tired of answering (Resident #G's) call light and I would have to do it. (CNA #15) said, 'She's getting on my nerves.' " When queried if she reported it to the Supervisor she stated, "No, but I talked about it with the other nurse." During interview with CNA #17 on 7/13/11 at 5:50 A.M., she indicated a resident complained to her that she was left in bed. CNA #15 would not take her to the bathroom when she needed to go. "She wasn't soiled, but she really gushed when I took her." 4. Resident #F's clinical record was reviewed on 7/13/11 at 4:00 P.M. and indicated diagnoses of, but not limited to, depression, osteoarthritis, and severe lumbar stenosis (narrowing of the vertebrae in the spine). During interview with CNA #4 on 7/13/11 at 5:25 A.M., she indicated several residents have complained to her about CNA #15 being rough with them. When queried who those residents were, she indicated Resident #F and Resident #G. Her information lead to conducted interviews with both Resident #F and Resident #G. (However, Resident #F indicated in the interview on 7/13/11 that it was CNA #2 who allegedly abused her.)			

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	Resident # F was identified as alert and oriented to person, place, and time by her physician in a History and Physical Report, dated 6/14/11, and by Social Service Staff #5 during an interview on 7/13/11 at 12:00 P.M. Resident #F's 14 day MDS (Minimum Data Set) Assessment, dated 6/17/11, indicted she was cognitively intact. She was admitted to the facility on 6/7/11 from an acute hospital. During interview with Resident #F on 7/13/11 at 9:15 A.M., she indicated that about 2 weeks ago, CNA #2 came into her room to assist her to the bathroom. CNA #2 insisted on putting Resident #F's back-brace on while she was sitting down. Resident #F told CNA #2 that Physical Therapist #6 told her she should be standing when the brace is put on her. CNA #2 responded, "I'll do it my way." Resident #F let her put the brace on while sitting because she was desperate to get to the bathroom. When she finished in the bathroom, CNA #2 assisted her to her bed. Resident #F, again, confronted CNA #2, this time regarding the position of the side rail on the bed. Resident #F informed CNA #2 that Physical Therapist #6 taught her to get into bed with the side rail down so she could position her body up higher on the mattress. CNA #2 replied in a snotty manner, "I'm not the therapist."			

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	Resident #F indicated she was sitting on the side of the bed when CNA #2 grabbed her by the sleeve and pulled her down toward the foot of the bed. "She then pushed my shoulders down on the bed, threw the pillow from my w/c onto the bed along with a sheet I used to cover my lap, and left me there. When she got angry her face got as red as an apple. I was afraid my back would get injured. I just had surgery and I don't want to have gone through all that pain for nothing. I'm just beginning to recover." Resident #F indicated she could not get anyone to help her, but when she saw CNA #3 outside her room she waved to her and she came to offer assistance. "She said, Oh dear, what happened to you? I told her what CNA #2 had done to me." Resident #F indicated CNA #3 had a physical condition which restricted her ability to lift, but together they managed to get her up in the bed. "She rescued me." When queried about the incident and what Resident #F was feeling at the time, she indicated she was fearful of CNA #2. .Resident #F indicated CNA #2 no longer provided her care, "I feel better that she isn't near me, but I would feel better if I didn't have to see her." Resident #F indicated she told the Director of Nursing (DON) the next day about CNA #2 and how she had frightened her. She indicated the DON was shocked and stated she had			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFIELD VILLAGE	6450 MIAMI CIRCLE SOUTH BEND, IN46614

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	never had any problems with CNA #2 in the past. "She told me CNA #2 would not be assigned to take care of me again." She further indicated the DON told her if she filed a report there could be legal ramifications as a result. The DON indicated in an interview on 7/13/11 at 11:00 A.M. that she had not suspended CNA #2 because Resident #F did not mention to her that CNA #2 threw her into bed, but that she was bossy and put her into the bed and left her feet hanging off the bed. "Forty-five minutes later, when I sought clarification, Resident #F told me her feet were on the bed and she used her foot to get her call light." The DON further indicated CNA #2 was one of her best workers. During an interview with the DON on 7/13/11 at 2:30 P.M., evidence of an investigation of the incident between Resident #F and CNA #2 on 7/4/11 was requested from the DON. The DON indicated she would retrieve it from her office but, just minutes later, the DON was observed interviewing LPN #7 regarding the incident that had been reported 8 days previously (7/5/11). The DON admitted she had not written up an investigation. When queried if she could produce any of the report, she produced a statement by CNA #2, dated 7/5/11, in			

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	which she relayed a completely different story of the incident. In her written statement, CNA #2 indicated Resident #F wanted to go to the bathroom and get into bed, but she informed the resident that the nurse would like her to sit up in the recliner. "She told me to put down the side rail. I told her to let me show her how we transfer with the rail up, so she could grab it. I helped he (sic) into bed and lifted her legs into bed. She got mad at me for not putting down the side rail and asked to see the nurse." CNA #2 indicated she went to LPN #7 and told her two or three times that Resident #F wanted to see her, but LPN #7 was too busy. The DON was observed on 7/13/11 at 2:45 P.M., writing the statement Resident #F provided her on 7/5/11, but was unable to produce documentation to indicate other residents and staff had been interviewed as part of an investigation. During a telephone conversation on 7/13/11 at 2:50 P.M. with CNA #3, while in the presence of the DON and with the "speaker phone" on, CNA #3 indicated she found Resident #F sideways in her bed. She further indicated Resident #F told her CNA #2 "threw her into bed and left her there." CNA #3 and LPN #7 failed to report the incident to the DON, but Resident #F had voiced mistreatment to her on 7/5/11.			

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	5. During interview with Resident #G on 7/13/11 at 10:35 A.M., she indicated she was fearful of using her call light because she had been yelled at by a staff person for having to go to the bathroom so much. "She would get angry when I had to go the bathroom. She was yelling 'Ever since they removed the catheter you've been a problem.' When someone knocks, I jump. I told them I was sorry, but I couldn't help it. Every time this need comes up (to use the bathroom) I get frightened. Recently, I had my light on, but no one came. I hurt because the pressure was so great. I took my blanket and folded it into a square and tucked it under me so I could pee on it without getting the rest of my bed wet. I reported that to (Social Service Staff #5) and the DON. Social Service Staff #5 indicated in an interview on 7/13/11 at 12:00 P.M. that he had been made aware of the situation and he met with Resident #G to discuss her feelings. He indicated this latest incident with the lack of a call light being answered happened on Monday, 7/11/11. "Resident #G has impaired vision and she was uncertain of the time, but she believed it was early morning around 5:00 A.M." During interview with the DON on 7/13/11 at 5:00 P.M., regarding the			

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	allegations made by Resident #G during interview with her on 7/13/11, she indicated she is still investigating the call light issue. Review of an "Internal Investigation" report, dated 4/15/11, it indicated, "Date of Occurrence: 4/2/11? or 4/3/11 Saturday night. Description of Occurrence: (Resident #G) c/o (complained of) a staff member complaining that she wants to go to the bathroom a lot and that her hands hurt after she grabbed her by the hands to take her into the bathroom...." A "Resident Statement" report, dated 4/4/11, indicated, "Sometimes I have vision and I can see...I think it was during the night or late evening. It was all about me having to go to the bathroom. This person was saying that I need to go to the bathroom all of the time. There was a time when I was. She said I had a problem. She was angry kind of. She said we need to do something about it...My hands are tender and she took me by the hands to take into the bathroom. They are sore...." A written statement by RN # 11, undated, indicated, "At 12 A (12:00 A.M.) 4/3/11, (Resident #G) began to tell me of an incident that she said happened last night. Attempted to clarify the time frame, but she was unsure. I gathered enough			

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	information to call in the morning to on call Supervisor. 7:45 A. M.-When I called LPN #12 (Supervisor), she called DON (Name) and requested a full statement and body check. Resident asked to tell what happened as it occurred. Resident (#G) didn't remember putting on call light, but someone came in, (Resident #G) said yelling at her. The following are statement contents and what she remembers. "You go (urinate) more than anyone I know." Resident (#G) said she needed to go to the bathroom. "I know this is all about going pee"...Someone grabbed her hands and was rough moving her around. "You need to do something about your bladder. You need to get your bladder checked. There is something wrong with you." Resident (#G) replied, "That may be true. (Resident #G) used the word 'forceful.' The person kept talking throughout the event to the bathroom and back. (Resident #G) said her face felt hot, and she was shaking all over...she said her hands hurt when they grabbed them...." The "Internal Investigation" further indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and			

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	wrists...." Report "Conclusion: (Resident #G) suffers from confusion. Statements from staff are providing nothing conclusive. Her son seems to think that she is repeating an old idea...." A "Resident/Family Concern Report," dated 4/18/11 and signed by the DON, indicated, "Concerning Resident #G Nature of Concern: This writer noted resident coming down the hall in her wheelchair being pushed by (CNA #13), I asked (Resident #G) how she was doing. She said, 'Not very good right now.' Upon further questioning she complained that one of the CNA's complained that she was 'peeing' too much....I questioned (CNA #8), the other CNA in her room this afternoon. (CNA #8) said 'I didn't say that, I just took her to the bathroom." Explained to CNA (#8) that resident's many times have (sic) to urinate frequently for different reasons and that we can't judge this. We merely take them to the bathroom...Resolution and Disposition: "...CNA apologized to resident. A letter to the Indiana State Department of Health, dated 5/9/11, which included the Incident Report (regarding CNA #8 and another accusation by Resident #B) indicated, "...(CNA #8) was also involved on 4/18/11 in a complaint made by			

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another resident, (Resident #G). She indicated that two CNA's complained that she urinated too frequently. One of these CNA's was (CNA #8)...."

Review of Resident #G's clinical record on 7//13/11 at 10:00 A.M., indicated diagnoses of, but not limited to, hypertension, hemiparesis, and legally blind. She was admitted to the facility on 3/3/11 from an acute hospital. A quarterly MDS (Minimum Data Set) Assessment, dated 6/31/11, indicated Resident #G's vision was severely impaired, was occasionally incontinent of urine and needed limited assistance of one for toileting.

During interview with CNA #14 on 5/13/11 at 5:50 A.M., she indicated residents frequently complain to her about a particular CNA refusing to toilet a resident. "I overheard (CNA #15) being rude to a resident. I heard her tell the resident, 'I can't take you to the bathroom again. You just went 10 minutes ago.' Three or four of us girls have gone to the nurses, but nothing seems to be done about it."

LPN #16 indicated in an interview on 5/13/11 at 5:45 A.M., "One night (CNA #15) came to me and told me she was tired of answering (Resident #G's) call

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	light and I would have to do it. (CNA #15) said, 'She's getting on my nerves.' " When queried if she reported it to the Supervisor she stated, "No, but I talked about it with the other nurse." During interview with CNA #17 on 7/13/11 at 5:50 A.M., she indicated a resident complained to her that she was left in bed. CNA #15 would not take her to the bathroom when she needed to go. "She wasn't soiled, but she really gushed when I took her." Review of a facility policy titled "Primary Abuse Prohibition Policy," dated 9/2000, indicated, "Policy: It shall be the policy of Southfield Village that all residents of this facility are free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion...Policy/Procedure Definitions: ...1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Also includes, Deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psycho-social well being. 2. Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within			

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	their hearing distance...(Examples: threats of harm, saying things to frighten a resident...4. Physical Abuse: Includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. 5. Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment of deprivation...Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness...Abuse-Identification of...Procedure: 1. ...staff and supervisory personnel will be cognizant of the potential for abuse of residents...2. The Administrator will be responsible for monitoring quality assurance and quality improvement progress reports for patterns, occurrences and trends that would be suggestive of abuse, neglect, ...within the facility. 3. The Administrator will be responsible for monitoring incident/accident reports for potential abuse...Investigation...Procedure: ...3. Staff incidents which involve abuse, neglect, ...are investigated as follows: 3.1 The staff member is suspended immediately without pay pending investigation. It is the intent of the facility to finalize an investigation within 3-5 days...." The immediate jeopardy that began on			

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	7/5/11 was removed on 7/15/11 when the facility suspended the staff accused of alleged abuse and began investigations, began immediate mandatory in-services on proper protocols to follow regarding abuse and neglect, reviewed facility's abuse policy and procedure and found it to be reasonable and accurate, met with all management staff and on-call nursing staff to review protocol for reporting abuse, revised the daily stand-up meeting form to include allegations of abuse and neglect, notified the facility Medical Director of the immediate jeopardy, posted phone numbers of the Administrator and Director of Nursing in multiple locations of the facility with instructions to immediately report any allegation of abuse at any time, ensured the Administrator or her designee will monitor abuse protocol by randomly interviewing five residents per week for no less than six months, and ensured the facility will continue to provide abuse and neglect education upon hire and at least twice annually, but the noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure staff continued to recognize and report abuse and monitor staff to ensure they continued to follow the corrective action plan.			

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	This Federal tag relates to complaint IN 00093132. 3.1-27(a)(1) 3-1.27(b)			

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F0225 SS=L	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure allegations of physical and verbal abuse were reported to State authorities as required, and in accordance with the facility's policy for 2	F0225	**F 225** Regarding Resident #B, CNA #8 was suspended on 5/4/11 after the facility became aware of the allegation. The CNA was terminated on 5/9/2011	07/18/2011

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	of 4 residents (Residents: #B, #D) reviewed for abuse in the sample of 4 and 2 of 6 residents (Residents: #F, #G) in the supplemental sample of 6. The immediate jeopardy began on 7/05/11 when Resident # F, who was recovering from recent back surgery, reported to CNA #3 on 7/4/11 that CNA #2 had thrown her into bed and left her sideways in the bed. Resident # F then reported the incident on 7/5/11 to the Director of Nursing who failed to suspend CNA #2 and protect other residents from potential harm during investigation of the alleged abuse. The Administrator and the Director of Nursing (DON) were notified of the immediate jeopardy at 5:30 P.M. on 7/13/11. The immediate jeopardy was: removed on 7/15/11, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Review of a facility "Incident Report," dated 5/3/11, indicated, "...(Resident #B) alleges that on Monday, 5-2-11, a CNA who gave her a shower treated her roughly and had a "bad attitude." She reported that she was sprayed in the face with the shower sprayer...."		following an investigation into the matter. This incident was reported to ISDH on 5/3/11. Regarding Resident #D, the facility has reviewed all grievances from this resident and/or family members and the facility alleges that this allegation was never reported to any member of administration at this facility. Resident #D has since been discharged from the facility. Because the facility was not aware of these allegations during her admission, an investigation into this alleged incident did not occur. Regarding Resident #F, the resident did not report to the facility that she had been thrown into bed. This allegation was not revealed to administration until the ISDH complaint surveyor interviewed the resident. As soon as the facility became aware of this allegation, CNA #2 was immediately suspended and an investigation was started. CNA #2 was terminated on 7/19/11. The surveyor was aware of this incident during the survey, and a follow-up report was sent to ISDH informing them of the facility's conclusion to the investigation on 7/19/11. Regarding Resident #G, CNA #8 was terminated on 5/9/11 and CNA #15 was terminated on 7/12/11. Mandatory in-services began	

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	A"Resident/Family Concern Report," dated 5/3/11, and signed by the Chaplain, indicated, "Nature of Concern: Resident (#B) reported rough handling and bad attitude of CNA #8 when resident asked repeatedly for bed pan last week. Resident #B thought she had asked 'someone in charge' to not have this CNA (#8) help with her care. Last evening, 5/2/11, (CNA #8) came to do (Resident #B's) shower. (Resident #8) reported she was sprayed in the face, and (CNA #8) was not following her wishes concerning (Resident #B's) clothing...." During interview with the DON on 7/12/11 at 2:30 P.M., she indicated she was unaware Resident #B requested CNA #8 not be assigned to provide her care. An "Investigation" report, dated 5/4/11 and signed by RN #9, indicated, "...The previous week Nurse (LPN #10) had called (Name), DON re: (regarding) a conflict between (Resident #B) and (CNA #8). (Resident #B) did not want (CNA #8) in her room. I was working Wing 200 that nite (sic) and overheard the phone conversation at the nurses station on Wed., April 27th." Review of CNA's Personnel File on 7/11/11 at 3:20 P.M. lacked		immediately upon the facility becoming aware of the immediate jeopardy citation on 7/13/11. All staff members were educated before the beginning of their next shift on: the proper protocol to report abuse, what types of things to report, and what to do if the report is not followed up on. Staff members were instructed to notify the Administrator, or designee in the Administrator's absence, immediately upon becoming aware of any abuse allegation. In-services for all staff were completed by 7/18/11. (Attachment A) Management and on-call nursing staff were in-serviced on 7/14/11 to review proper protocol for reporting abuse. (Included in Attachment A) The facility Administrator reviewed the facility's policies and procedures regarding abuse and neglect on 7/13/11. They were found to be reasonable and accurate. However, after further review, minor modifications were made to the policy, "Abuse- Identification of and Protection of the Resident" to simplify the language and the procedure for staff members. (Attachment B) The facility Medical Director was notified of the immediate jeopardy citation on 7/14/11. The phone numbers of the	

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	documentation of an investigation, a State reportable, counseling, or disciplinary action regarding the issue reported by LPN #10 regarding Resident #B's accusation of alleged rough handling by CNA #8 when assisting her with the bedpan (4/27/11). Resident #B's closed clinical record was reviewed on 7/11/11 at 3:45 P.M., and indicated diagnoses of, but not limited to, congestive heart failure, hypertension (high blood pressure), and severe osteoporosis (abnormal loss of bone density). An initial MDS (Minimum Data Set) Assessment, dated 4/15/11, indicated she was moderately cognitively impaired with a score of 12 out of 15. 2. The closed clinical record of Resident #D was reviewed on 7/12/11 at 10:45 A.M. and indicated diagnoses of, but not limited to, vertebral compression fracture, macular degeneration (progressive deterioration in the eye which leads to blindness), peripheral vascular disease (restricted blood flow), fractured left hip, and spinal stenosis (narrowing of the vertebrae). During interview with Resident #D's daughter on 7/11/11 at 2:15 P.M., Resident #D's daughter indicated her mother had told her that a night CNA		Administrator and Director of Nursing were posted in multiple locations on 7/14/11 in order for any staff member to directly notify administration of any allegations of abuse, at any time. The form used as a guide for discussion in daily stand-up meeting was revised on 7/14/11 to include the statement, “Allegations of abuse or neglect?” (Attachment C) In order to ensure all staff are educated on abuse and neglect on an ongoing basis, the facility will continue to provide education on this subject upon hire and at least twice annually. In order to monitor and ensure that abuse policies are followed, the Administrator or her designee, will randomly interview five residents per week for a time period of no less than six months as to how staff members have been treating them. Any concerns will be thoroughly investigated. (Attachment D) Results of the monitoring program will be reviewed at the monthly CQI (Continuous Quality Improvement) meeting. Areas of non-compliance will be addressed immediately. Alleged date of compliance is 7/18/2011.	

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	cussed at her, threw her in bed, and told her "I'm tired of you using that d--n call light. I'm tired of coming into your room. "My mother complained 'They're mean to me. They're mean to me.' I, at first, thought my mother was imagining it, but when the bruises and tremors were evident, I went to the DON with my concerns. I told her mother described the CNA as (race stated), tall woman. The DON said, 'We don't have a tall (race stated) girl working here.' My mother was lying in bed and looking up at the individual which probably made her look tall." In a second interview with Resident #D's daughter on 7/12/11 at 9:20 A.M., she indicated she asked her mother if she could remember the name of the CNA who was rough with her. "It was a (race stated) girl in the middle of the night." "She did complain to the DON (Name) about the treatment. We were very upset when the bruises were discovered at the hospital. Mother remembers them shoving her around and slamming her into bed and she told them, 'Be careful your going to break my hip, again.' " Review of Resident #D's initial MDS (Minimum Data Set) Assessment, dated 5/18/11, indicated she was cognitively intact with a score of 15 out of 15.			

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During interview with the DON on 7/12/11 at 10:35 A.M., she indicated she was able to validate with the resident that the CNA was just hurrying. She further indicated, as a result, she did not feel there was a need to do a State Reportable.

The Nursing staff schedule was reviewed and indicated CNA #15 was the only (race stated) CNA who provided care to Resident #D on the night shift. The May and June, 2011 schedules indicated CNA was assigned to provide care to Resident #D on the following dates: 5/24, 5/31, 6/7, 6/14, 6/18, and 6/19/11.

CNA #15's Personnel File was reviewed on 7/12/11 at 4:15 P.M. and lacked documentation or any proof of investigation regarding Resident #D or her family's alleged abuse by CNA #15.

Resident #D's clinical record also lacked documentation of alleged abuse or investigation of any alleged abuse.

During interview with CNA #14 on 5/13/11 at 5:50 A.M., she indicated residents frequently complained to her about a particular CNA refusing to toilet a resident. "I overheard (CNA #15) being rude to a resident. I heard her tell the resident, 'I can't take you to the bathroom

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again. You just went 10 minutes ago.' Three or four of us girls have gone to the nurse's, but nothing seems to be done about it."

LPN #16 indicated in an interview on 5/13/11 at 5:45 A.M., One night (CNA #15) came to me and told me she was tired of answering (Resident #G's) call light and I would have to do it. (CNA #15) said, "She's getting on my nerves." When queried if she reported it to the Supervisor she stated, "No, but I talked about it with the other nurse."

During interview with CNA #17 on 7/13/11 at 5:50 A.M., she indicated a resident complained to her that she was left in bed. CNA #15 would not take her to the bathroom when she needed to go. "She wasn't soiled, but she really gushed when I took her."

3. Resident #F's clinical record was reviewed on 7/13/11 at 4:00 P.M. and indicated diagnoses of, but not limited to, depression, osteoarthritis, and severe lumbar stenosis (narrowing of the vertebrae in the spine).

During interview with CNA # 4 on 7/13/11 at 5:25 A.M., she indicated several residents have complained to her about CNA #15 being rough with them.

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	When queried who those residents were, she indicated Resident #F and Resident #G. Her information lead to conducted interviews with both Resident #F and Resident #G. (However, Resident #F indicated in the interview on 7/13/11 that it was CNA #2 who allegedly abused her.) Resident # F was identified as alert and oriented to person, place, and time by her physician in a History and Physical Report, dated 6/14/11, and by Social Service Staff #5 during an interview on 7/13/11 at 12:00 P.M. Resident #F's 14 day MDS (Minimum Data Set) Assessment, dated 6/17/11, indicted she was cognitively intact. She was admitted to the facility on 6/7/11 from an acute hospital. During interview with Resident #F on 7/13/11 at 9:15 A.M., she indicated that about 2 weeks ago, CNA #2 came into her room to assist her to the bathroom. CNA #2 insisted on putting Resident #F's back-brace on while she was sitting down. Resident #F told CNA #2 that Physical Therapist #6 told her she should be standing when the brace is put on her. CNA #2 responded, "I'll do it my way." Resident #F let her put the brace on while sitting because she was desperate to get to the bathroom. When she finished in the bathroom, CNA #2 assisted her to her bed.			

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	Resident #F, again, confronted CNA #2, this time regarding the position of the side rail on the bed. Resident #F informed CNA #2 that Physical Therapist #6 taught her to get into bed with the side rail down so she could position her body up higher on the mattress. CNA #2 replied in a snotty manner, "I'm not the therapist." Resident #F indicated she was sitting on the side of the bed when CNA #2 grabbed her by the sleeve and pulled her down toward the foot of the bed. "She then pushed my shoulders down on the bed, threw the pillow from my w/c onto the bed along with a sheet I used to cover my lap, and left me there. When she got angry her face got as red as an apple. I was afraid my back would get injured. I just had surgery and I don't want to have gone through all that pain for nothing. I'm just beginning to recover." Resident #F indicated she could not get anyone to help her, but when she saw CNA #3 outside her room she waved to her and she came to offer assistance. "She said, Oh dear, what happened to you? I told her what CNA #2 had done to me." Resident #F indicated CNA #3 had a physical condition which restricted her ability to lift, but together they managed to get her up in the bed. "She rescued me." When queried about the incident and what Resident #F was feeling at the time, she indicated she was fearful of CNA #2.			

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	.Resident #F indicated CNA #2 no longer provided her care, "I feel better that she isn't near me, but I would feel better if I didn't have to see her." Resident #F indicated she told the Director of Nursing (DON) the next day about CNA #2 and how she had frightened her. She indicated the DON was shocked and stated she had never had any problems with CNA #2 in the past. "She told me CNA #2 would not be assigned to take care of me again." She further indicated the DON told her if she filed a report there could be legal ramifications as a result. The DON indicated in an interview on 7/13/11 at 11:00 A.M. that she had not suspended CNA #2 because Resident #F did not mention to her that CNA #2 threw her into bed, but that she was bossy and put her into the bed and left her feet hanging off the bed. "Forty-five minutes later, when I sought clarification, Resident #F told me her feet were on the bed and she used her foot to get her call light." The DON further indicated CNA #2 was one of her best workers. Resident #F's clinical record lacked documentation of an investigation, a State Reportable, counseling, or disciplinary action regarding the issue reported to the DON on 7/5/11 by Resident #F..			

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	During an interview with the DON on 7/13/11 at 2:30 P.M., evidence of an investigation of the incident between Resident #F and CNA #2 on 7/4/11 was requested from the DON. The DON indicated she would retrieve it from her office but, just minutes later, the DON was observed interviewing LPN #7 regarding the incident that had been reported 8 days previously (7/5/11). The DON admitted she had not written up an investigation. When queried if she could produce any of the report, she produced a statement by CNA #2, dated 7/5/11. There was no other documentation which indicated suspension, investigation, counseling, or disciplinary action had taken place. In her statement of 7/5/11, CNA #2 relayed a completely different story of the incident. CNA #2 indicated Resident #F wanted to go to the bathroom and get into bed, but she informed the resident that the nurse would like her to sit up in the recliner. "She told me to put down the side rail. I told her to let me show her how we transfer with the rail up, so she could grab it. I helped he (sic) into bed and lifted her legs into bed. She got mad at me for not putting down the side rail and asked to see the nurse." CNA #2 indicated she went to LPN #7 and told her two or three times that Resident #F wanted to see her, but LPN #7 was too busy. The DON was observed on 7/13/11			

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	at 2:45 P.M., writing the statement Resident #F provided her on 7/5/11, but was unable to produce documentation to indicate other residents and staff had been interviewed as part of an investigation. During a telephone conversation on 7/13/11 at 2:50 P.M. with CNA #3, while in the presence of the DON and with the "speaker phone" on, CNA #3 indicated she found Resident #F sideways in her bed. She further indicated Resident #F told her CNA #2 "threw her into bed and left her there." CNA #3 and LPN #7 failed to report the incident to the DON, but Resident #F had voiced mistreatment to her on 7/5/11. 4. During interview with Resident #G on 7/13/11 at 10:35 A.M., she indicated she was fearful of using her call light because she had been yelled at by a staff person for having to go to the bathroom so much. "She would get angry when I had to go the bathroom. She was yelling 'Ever since they removed the catheter you've been a problem.' When someone knocks, I jump. I told them I was sorry, but I couldn't help it. Every time this need comes up (to use the bathroom) I get frightened. Recently, I had my light on, but no one came. I hurt because the pressure was so great. I took my blanket and folded it into a square and tucked it under me so I could pee on it without getting the rest of my bed wet.			

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	I reported that to (Social Service Staff #5) and the DON. Social Service Staff #5 indicated in an interview on 7/13/11 at 12:00 P.M. that he had been made aware of the situation and he met with Resident #G to discuss her feelings. He indicated this latest incident with the lack of a call light being answered happened on Monday, 7/11/11. "Resident #G has impaired vision and she was uncertain of the time, but she believed it was early morning around 5:00 A.M." During interview with the DON on 7/13/11 at 5:00 P.M., regarding the allegations made by Resident #G during interview with her on 7/13/11, she indicated she is still investigating the call light issue. Review of an "Internal Investigation" report, dated 4/15/11, indicated, "Date of Occurrence: 4/2/11? or 4/3/11 Saturday night. Description of Occurrence: (Resident #G) c/o (complained of) a staff member complaining that she wants to go to the bathroom a lot and that her hands hurt after she grabbed her by the hands to take her into the bathroom...." A "Resident Statement" report, dated 4/4/11, indicated, "Sometimes I have vision and I can see...I think it was during the night or late			

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	evening. It was all about me having to go to the bathroom. This person was saying that I need to go to the bathroom all of the time. There was a time when I was. She said I had a problem. She was angry kind of. She said we need to do something about it...My hands are tender and she took me by the hands to take into the bathroom. They are sore...." A written statement by RN # 11, undated, indicated, "At 12 A (12:00 A.M.) 4/3/11, (Resident #G) began to tell me of an incident that she said happened last night. Attempted to clarify the time frame, but she was unsure. I gathered enough information to call in the morning to on call Supervisor. 7:45 A. M.-When I called LPN #12 (Supervisor), she called DON (Name) and requested a full statement and body check. Resident asked to tell what happened as it occurred. Resident (#G) didn't remember putting on call light, but someone came in, (Resident #G) said yelling at her. The following are statement contents and what she remembers. "You go (urinate) more than anyone I know." Resident (#G) said she needed to go to the bathroom. "I know this is all about going pee"...Someone grabbed her hands and was rough moving her around. "You need to do something about your bladder. You need to get your bladder checked. There is something			

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	wrong with you." Resident (#G) replied, "That may be true). (Resident #G) used the word 'forceful.' The person kept talking throughout the event to the bathroom and back. (Resident #G) said her face felt hot, and she was shaking all over...she said her hands hurt when they grabbed them...." The "Internal Investigation" further indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and wrists...." Report "Conclusion: (Resident #G) suffers from confusion. Statements from staff are providing nothing conclusive. Her son seems to think that she is repeating an old idea...." Resident #G's clinical record indicated she was admitted to the facility from an acute care hospital on 3/3/11. A "Resident/Family Concern Report," dated 4/18/11 and signed by the DON, indicated, "Concerning Resident #G Nature of Concern: This writer noted resident coming down the hall in her wheelchair being pushed by (CNA #13), I asked (Resident #G) how she was doing. She said, 'Not very good right now.' Upon further questioning she complained that			

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	one of the CNA's complained that she was 'peeing' too much....I questioned (CNA #8), the other CNA in her room this afternoon. (CNA #8) said 'I didn't say that, I just took her to the bathroom." Explained to CNA (#8) that resident's many times have (sic) to urinate frequently for different reasons and that we can't judge this. We merely take them to the bathroom...Resolution and Disposition: "...CNA apologized to resident. A letter to the Indiana State Department of Health, dated 5/9/11, which included the Incident Report (regarding CNA #8 and another accusation by Resident #B) indicated, "...(CNA #8) was also involved on 4/18/11 in a complaint made by another resident, (Resident #G). She indicated that two CNA's complained that she urinated too frequently. One of these CNA's was (CNA #8)...." Resident #G's clinical record and the Personnel File of CNA #8, lacked documentation that the 4/2/11 and the 4/18/11 complaint of alleged abuse by Resident #G were reported to State authorities. It was briefly mentioned (21 days later) in the above letter and incident report, dated 5/9/11. Review of Resident #G's clinical record			

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	on 7//13/11 at 10:00 A.M., indicated diagnoses of, but not limited to, hypertension, hemiparesis, and legally blind. A quarterly MDS (Minimum Data Set) Assessment, dated 5/31/11, indicated Resident #G's vision was severely impaired, she was occasionally incontinent of urine, and needed limited assistance of one for toileting. She scored 11 of 15 for cognicity, which indicated she was moderately impaired. Review of a facility policy titled "Primary Abuse Prohibition Policy," dated 9/2000, indicated, "Policy: It shall be the policy of Southfield Village that all residents of this facility are free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion...Policy/Procedure ...Abuse-Identification of...Procedure: 1. ...staff and supervisory personnel will be cognizant of the potential for abuse of residents...2. The Administrator will be responsible for monitoring quality assurance and quality improvement progress reports for patterns, occurrences and trends that would be suggestive of abuse, neglect, ...within the facility. 3. The Administrator will be responsible for monitoring incident/accident reports for potential abuse...Investigation...Procedure: ...3. Staff incidents which involve abuse,			

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	neglect, ...are investigated as follows: 3.1 The staff member is suspended immediately without pay pending investigation. It is the intent of the facility to finalize an investigation within 3-5 days...." The immediate jeopardy that began on 7/5/11 was removed on 7/15/11 when the facility suspended the staff accused of alleged abuse and began investigations, began immediate mandatory in-services on proper protocols to follow regarding abuse and neglect, reviewed facility's abuse policy and procedure and found it to be reasonable and accurate, met with all management staff and on-call nursing staff to review protocol for reporting abuse, revised the daily stand-up meeting form to include allegations of abuse and neglect, notified the facility Medical Director of the immediate jeopardy, posted phone numbers of the Administrator and Director of Nursing in multiple locations of the facility with instructions to immediately report any allegation of abuse at any time, ensured the Administrator or her designee will monitor abuse protocol by randomly interviewing five residents per week for no less than six months, and ensured the facility will continue to provide abuse and neglect education upon hire and at least twice annually, but the noncompliance			

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	remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure staff continued to recognize and report abuse and monitor staff to ensure they continued to follow the corrective action plan. This Federal tag relates to complaint IN 00093132. 3.1-28(c) 3.1-28(d)			
F0226 SS=L	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their written protocol regarding abuse and neglect to ensure staff recognized allegations of physical and verbal abuse and immediately reported those allegations to the Administrator for investigation to prevent the abuse from reoccurring. This deficient practice affected 2 of 4 residents	F0226	**F 226** Regarding Resident #B, CNA #8 was suspended on 5/4/11 after the facility became aware of the allegation. The CNA was terminated on 5/9/2011 following an investigation into the matter. This incident was reported to ISDH on 5/3/11. Regarding Resident #D, the facility	07/18/2011

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	(Residents: #B, #D) reviewed for abuse in the sample of 4 and 2 of 6 residents (Residents: #F, #G) in the supplemental sample of 6 with the potential to affect all 60 residents residing in the facility. The immediate jeopardy began on 7/05/11 when Resident # F, who was recovering from recent back surgery, reported to CNA #3 on 7/4/11 that CNA #2 had thrown her into bed and left her sideways in the bed. Resident # F then reported the incident on 7/5/11 to the Director of Nursing who failed to suspend CNA #2 and protect other residents from potential harm during investigation of the alleged abuse. The Administrator and the Director of Nursing (DON) were notified of the immediate jeopardy at 5:30 P.M. on 7/13/11. The immediate jeopardy was: removed on 7/15/11, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Review of a facility "Incident Report," dated 5/3/11, indicated, "...(Resident #B) alleges that on Monday, 5-2-11, a CNA who gave her a shower treated her roughly and had a "bad attitude." She reported that she was sprayed in the face with the		has reviewed all grievances from this resident and/or family members and the facility alleges that this allegation was never reported to any member of administration at this facility. Resident #D has since been discharged from the facility. Because the facility was not aware of these allegations during her admission, an investigation into this alleged incident did not occur. Regarding Resident #F, the resident did not report to the facility that she had been thrown into bed. This allegation was not revealed to administration until the ISDH complaint surveyor interviewed the resident. As soon as the facility became aware of this allegation, CNA #2 was immediately suspended and an investigation was started. CNA #2 was terminated on 7/19/11. The surveyor was aware of this incident during the survey, and a follow-up report was sent to ISDH informing them of the facility's conclusion to the investigation on 7/19/11. Regarding Resident #G, CNA #8 was terminated on 5/9/11 and CNA #15 was terminated on 7/12/11. Mandatory in-services began immediately upon the facility becoming aware of the immediate jeopardy citation on 7/13/11. All staff members were educated before the beginning of their next shift on:	

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	shower sprayer...." A"Resident/Family Concern Report," dated 5/3/11, and signed by the Chaplain, indicated, "Nature of Concern: Resident (#B) reported rough handling and bad attitude of CNA #8 when resident asked repeatedly for bed pan last week. Resident #B thought she had asked 'someone in charge' to not have this CNA (#8) help with her care. Last evening, 5/2/11, (CNA #8) came to do (Resident #B's) shower. (Resident #8) reported she was sprayed in the face, and (CNA #8) was not following her wishes concerning (Resident #B's) clothing...." During interview with the DON on 7/12/11 at 2:30 P.M., she indicated she was unaware Resident #B requested CNA #8 not be assigned to provide her care. An "Investigation" report, dated 5/4/11 and signed by RN #9, indicated, "On Monday, May 2nd, approx (approximately) 9:00 P.M., I entered (Resident #B's) (room number) with her H.S. (bedtime) meds (medications). (CNA #8) had just showered her. (Resident #B) said to me: 'I don't know what is wrong with that girl. I don't like the way she handles me. When I saw her face I knew I was in for it'...The previous week Nurse (LPN #10) had called		the proper protocol to report abuse, what types of things to report, and what to do if the report is not followed up on. Staff members were instructed to notify the Administrator, or designee in the Administrator's absence, immediately upon becoming aware of any abuse allegation. In-services for all staff were completed by 7/18/11. (Attachment A) Management and on-call nursing staff were in-serviced on 7/14/11 to review proper protocol for reporting abuse. (Included in Attachment A) The facility Administrator reviewed the facility's policies and procedures regarding abuse and neglect on 7/13/11. They were found to be reasonable and accurate. However, after further review, minor modifications were made to the policy, "Abuse- Identification of and Protection of the Resident" to simplify the language and the procedure for staff members. (Attachment B) The facility Medical Director was notified of the immediate jeopardy citation on 7/14/11. The phone numbers of the Administrator and Director of Nursing were posted in multiple locations on 7/14/11 in order for any staff member to directly notify administration of any allegations of	

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	(Name), DON re: (regarding) a conflict between (Resident #B) and (CNA #8). (Resident #B) did not want (CNA #8) in her room. I was working Wing 200 that nite (sic) and overheard the phone conversation at the nurses station on Wed., April 27th." Review of the "CNA Evening Assignment," dated 5/2/11, indicated CNA #8 had been assigned to (Resident #B's) room. Review of CNA #8's personnel File on 7/11/11 at 3:20 P.M. lacked documentation of an investigation, a State Reportable, counseling, or disciplinary action regarding the issue reported by LPN #10 regarding Resident #B's accusation of alleged rough handling by CNA #8 when assisting her with the bedpan (4/27/11). An "Employee Counseling Form," dated 5/3/11, indicated CNA #8 was suspended 5/3/11 pending investigation. The DON indicated in the interview on 7/12/11 at 2:30 P.M. that CNA #8 had been terminated on 5/9/11. Resident #B's closed clinical record was reviewed on 7/11/11 at 3:45 P.M., and indicated diagnoses of, but not limited to, congestive heart failure, hypertension		abuse, at any time. The form used as a guide for discussion in daily stand-up meeting was revised on 7/14/11 to include the statement, “Allegations of abuse or neglect?” (Attachment C) In order to ensure all staff are educated on abuse and neglect on an ongoing basis, the facility will continue to provide education on this subject upon hire and at least twice annually. In order to monitor and ensure that abuse policies are followed, the Administrator or her designee, will randomly interview five residents per week for a time period of no less than six months as to how staff members have been treating them. Any concerns will be thoroughly investigated. (Attachment D) Results of the monitoring program will be reviewed at the monthly CQI (Continuous Quality Improvement) meeting. Areas of non-compliance will be addressed immediately. Alleged date of compliance is 7/18/2011.	

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	(high blood pressure), and severe osteoporosis (abnormal loss of bone density). An initial MDS (Minimum Data Set) Assessment, dated 4/15/11, indicated she was moderately cognitively impaired with a score of 12 out of 15. 2. The closed clinical record of Resident #D was reviewed on 7/12/11 at 10:45 A.M. and indicated diagnoses of, but not limited to, vertebral compression fracture, macular degeneration (progressive deterioration in the eye which leads to blindness), peripheral vascular disease (restricted blood flow), fractured left hip, and spinal stenosis (narrowing of the vertebrae). During interview with Resident #D's daughter on 7/11/11 at 2:15 P.M., she indicated her mother had told her that a night CNA cussed at her, threw her in bed, and told her "I'm tired of you using that d--n call light. I'm tired of coming into your room. "My mother complained 'They're mean to me. They're mean to me.' I, at first, thought my mother was imagining it, but when the bruises and tremors were evident, I went to the DON with my concerns. I told her mother described the CNA as being a (race stated), tall woman. The DON said, 'We don't have a tall (race stated) girl working here.' My mother was lying in bed and			

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	looking up at the individual which probably made her look tall." In a second interview with Resident #D's daughter on 7/12/11 at 9:20 A.M., she indicated she asked her mother if she could remember the name of the CNA who was rough with her. "It was a (race stated) girl in the middle of the night." "She did complain to the DON (Name) about the treatment. We were very upset when the bruises were discovered at the hospital. Mother remembers them shoving her around and slamming her into bed and she told them, 'Be careful your going to break my hip, again.' " Review of Resident #D's initial MDS (Minimum Data Set) Assessment, dated 5/18/11, indicated she was cognitively intact with a score of 15 out of 15. During interview with the DON on 7/12/11 at 10:35 A.M., she indicated she was able to validate with the resident that the CNA was just hurrying. She further indicated, as a result, she did not feel there was a need to do a State Reportable. The Nursing staff schedule was reviewed and indicated CNA #15 was the only (race stated) CNA who provided care to Resident #D on the night shift. The May and June, 2011 schedules indicated CNA			

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	was assigned to provide care to Resident #D on the following dates: 5/24, 5/31, 6/7, 6/14, 6/18, and 6/19/11. CNA #15's Personnel File was reviewed on 7/12/11 at 4:15 P.M. and lacked documentation or any proof of investigation or reporting to State authorities the abuse allegations by Resident #D or her family. Resident #D's clinical record also lacked documentation of alleged abuse or investigation of any alleged abuse. 3. Resident #F's clinical record was reviewed on 7/13/11 at 4:00 P.M. and indicated diagnoses of, but not limited to, depression, osteoarthritis, and severe lumbar stenosis (narrowing of the vertebrae in the spine). During interview with CNA # 4 on 7/13/11 at 5:25 A.M., she indicated several residents have complained to her about CNA #15 being rough with them. When queried who those residents were, she indicated Resident #F and Resident #G. Her information lead to conducted interviews with both Resident #F and Resident #G. (However, Resident #F indicated it was CNA #2 who allegedly abused her.)			

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	Resident # F was identified as alert and oriented to person, place, and time by her physician in a History and Physical Report, dated 6/14/11, and by Social Service Staff #5 during an interview on 7/13/11 at 12:00 P.M. Resident #F's 14 day MDS (Minimum Data Set) Assessment, dated 6/17/11, indicted she was cognitively intact. She was admitted to the facility on 6/7/11 from an acute hospital. During interview with Resident #F on 7/13/11 at 9:15 A.M., she indicated that about 2 weeks ago, CNA #2 came into her room to assist her to the bathroom. CNA #2 insisted on putting Resident #F's back-brace on while she was sitting down. Resident #F told CNA #2 that Physical Therapist #6 told her she should be standing when the brace is put on her. CNA #2 responded, "I'll do it my way." Resident #F let her put the brace on while sitting because she was desperate to get to the bathroom. When she finished in the bathroom, CNA #2 assisted her to her bed. Resident #F, again, confronted CNA #2, this time regarding the position of the side rail on the bed. Resident #F informed CNA #2 that Physical Therapist #6 taught her to get into bed with the side rail down so she could position her body up higher on the mattress. CNA #2 replied in a snotty manner, "I'm not the therapist."			

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	Resident #F indicated she was sitting on the side of the bed when CNA #2 grabbed her by the sleeve and pulled her down toward the foot of the bed. "She then pushed my shoulders down on the bed, threw the pillow from my w/c onto the bed along with a sheet I used to cover my lap, and left me there. When she got angry her face got as red as an apple. I was afraid my back would get injured. I just had surgery and I don't want to have gone through all that pain for nothing. I'm just beginning to recover." Resident #F indicated she could not get anyone to help her, but when she saw CNA #3 outside her room she waved to her and she came to offer assistance. "She said, Oh dear, what happened to you? I told her what CNA #2 had done to me." Resident #F indicated CNA #3 had a physical condition which restricted her ability to lift, but together they managed to get her up in the bed. "She rescued me." When queried about the incident and what Resident #F was feeling at the time, she indicated she was fearful of CNA #2. .Resident #F indicated CNA #2 no longer provided her care, "I feel better that she isn't near me, but I would feel better if I didn't have to see her." Resident #F indicated she told the Director of Nursing (DON) the next day about CNA #2 and how she had frightened her. She indicated the DON was shocked and stated she had			

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	never had any problems with CNA #2 in the past. "She told me CNA #2 would not be assigned to take care of me again." She further indicated the DON told her if she filed a report there could be legal ramifications as a result. The DON indicated in an interview on 7/13/11 at 11:00 A.M. that she had not suspended CNA #2 because Resident #F did not mention to her that CNA #2 threw her into bed, but that she was bossy and put her into the bed and left her feet hanging off the bed. "Forty-five minutes later, when I sought clarification, Resident #F told me her feet were on the bed and she used her foot to get her call light." The DON further indicated CNA #2 was one of her best workers. During an interview with the DON on 7/13/11 at 2:30 P.M., evidence of an investigation of the incident between Resident #F and CNA #2 on 7/4/11 was requested from the DON. The DON indicated she would retrieve it from her office, but, just minutes later, the DON was observed interviewing LPN #7 regarding the incident that had been reported 8 days previously (7/5/11). The DON admitted she had not written up an investigation. When queried if she could produce any of the report, she produced a statement by CNA #2, dated 7/5/11.			

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	There was no other documentation which indicated suspension, investigation, reporting to State authorities, counseling, or disciplinary action had taken place. In her statement of 7/5/11, CNA #2 relayed a completely different story of the incident. CNA #2 indicated Resident #F wanted to go to the bathroom and get into bed, but she informed the resident that the nurse would like her to sit up in the recliner. "She told me to put down the side rail. I told her to let me show her how we transfer with the rail up, so she could grab it. I helped he (sic) into bed and lifted her legs into bed. She got mad at me for not putting down the side rail and asked to see the nurse." CNA #2 indicated she went to LPN #7 and told her two or three times that Resident #F wanted to see her, but LPN #7 was too busy. The DON was observed on 7/13/11 at 2:45 P.M., writing the statement Resident #F provided her on 7/5/11, but was unable to produce documentation to indicate other residents and staff had been interviewed as part of an investigation. During a telephone conversation on 7/13/11 at 2:50 P.M. with CNA #3, while in the presence of the DON and with the "speaker phone" on, CNA #3 indicated she found Resident #F sideways in her bed. She further indicated Resident #F told her CNA #2 "threw her into bed and left her there." CNA #3 and LPN #7 failed to report the incident to the			

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	DON, but Resident #F had voiced mistreatment to her on 7/5/11. 4. During interview with Resident #G on 7/13/11 at 10:35 A.M., she indicated she was fearful of using her call light because she had been yelled at by a staff person for having to go to the bathroom so much. "She would get angry when I had to go the bathroom. She was yelling 'Ever since they removed the catheter you've been a problem.' When someone knocks, I jump. I told them I was sorry, but I couldn't help it. Every time this need comes up (to use the bathroom) I get frightened. Recently, I had my light on, but no one came. I hurt because the pressure was so great. I took my blanket and folded it into a square and tucked it under me so I could pee on it without getting the rest of my bed wet. I reported that to (Social Service Staff #5) and the DON. Social Service Staff #5 indicated in an interview on 7/13/11 at 12:00 P.M. that he had been made aware of the situation and he met with Resident #G to discuss her feelings. He indicated this latest incident with the lack of a call light being answered happened on Monday, 7/11/11. "Resident #G has impaired vision and she was uncertain of the time, but she believed it was early morning around 5:00 A.M."			

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During interview with the DON on 7/13/11 at 5:00 P.M., regarding the allegations made by Resident #G during interview with her on 7/13/11, she indicated she is still investigating the call light issue.

Review of an "Internal Investigation" report, dated 4/15/11, it indicated, "Date of Occurrence: 4/2/11? or 4/3/11 Saturday night. Description of Occurrence: (Resident #G) c/o (complained of) a staff member complaining that she wants to go to the bathroom a lot and that her hands hurt after she grabbed her by the hands to take her into the bathroom...." A "Resident Statement" report, dated 4/4/11, indicated, "Sometimes I have vision and I can see...I think it was during the night or late evening. It was all about me having to go to the bathroom. This person was saying that I need to go to the bathroom all of the time. There was a time when I was. She said I had a problem. She was angry kind of. She said we need to do something about it...My hands are tender and she took me by the hands to take into the bathroom. They are sore...."

A written statement by RN # 11, undated, indicated, "At 12 A (12:00 A.M.) 4/3/11, (Resident #G) began to tell me of an

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	incident that she said happened last night. Attempted to clarify the time frame, but she was unsure. I gathered enough information to call in the morning to on call Supervisor. 7:45 A. M.-When I called LPN #12 (Supervisor), she call DON (Name) and requested a full statement and body check. Resident asked to tell what happened as it occurred. Resident (#G) didn't remember putting on call light, but someone came in, (Resident #G) said yelling at her. The following are statement contents and what she remembers. "You go (urinate) more than anyone I know." Resident (#G) said she needed to go to the bathroom. "I know this is all about going pee"...Someone grabbed her hands and was rough moving her around. "You need to do something about your bladder. You need to get your bladder checked. There is something wrong with you." Resident (#G) replied, "That may be true. (Resident #G) used the word 'forceful.' The person kept talking throughout the event to the bathroom and back. (Resident #G) said her face felt hot, and she was shaking all over...she said her hands hurt when they grabbed them...." The "Internal Investigation," dated "4/2/11 ? or 4/3/11", further indicated Resident G's son made the statement on 4/4/11, "I think this story about someone			

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	complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and wrists...." Report "Conclusion: (Resident #G) suffers from confusion. Statements from staff are providing nothing conclusive. Her son seems to think that she is repeating an old idea...." A "Resident/Family Concern Report," dated 4/18/11 and signed by the DON, indicated, "Concerning Resident #G Nature of Concern: This writer noted resident coming down the hall in her wheelchair being pushed by (CNA #13), I asked (Resident #G) how she was doing. She said, 'Not very good right now.' Upon further questioning she complained that one of the CNA's complained that she was 'peeing' too much....I questioned (CNA #8), the other CNA in her room this afternoon. (CNA #8) said 'I didn't say that, I just took her to the bathroom." Explained to CNA (#8) that resident's many times have (sic) to urinate frequently for different reasons and that we can't judge this. We merely take them to the bathroom...Resolution and Disposition: "...CNA apologized to resident. A letter to the Indiana State Department of Health, dated 5/9/11, which included the			

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	Incident Report (regarding CNA #8 and another accusation by Resident #B) indicated, "...(CNA #8) was also involved on 4/18/11 in a complaint made by another resident, (Resident #G). She indicated that two CNA's complained that she urinated too frequently. One of these CNA's was (CNA #8)...." Resident #G's clinical record and the Personnel Record of CNA #8, lacked documentation that the 4/2/11 and the 4/18/11 complaint of alleged abuse by Resident #G was reported to State authorities. It was briefly mentioned (21 days later) in the above letter and incident report, dated 5/9/11. Review of Resident #G's clinical record on 7//13/11 at 10:00 A.M., indicated diagnoses of, but not limited to, hypertension, hemiparesis, and legally blind. She was admitted to the facility on 3/3/11 from an acute hospital. A quarterly MDS (Minimum Data Set) Assessment, dated 6/31/11, indicated Resident #G's vision was severely impaired, was occasionally incontinent of urine and needed limited assistance of one for toileting. The Administrator indicated in an interview on 4/14/11 at 4:00 P.M., she was unaware of the abuse allegations.			

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	"The Director of Nursing has always addressed those issues. The previous DON did the same thing." Review of a facility policy titled "Primary Abuse Prohibition Policy," dated 9/2000, indicated, "Policy: It shall be the policy of Southfield Village that all residents of this facility are free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion...Policy/Procedure Definitions: ...1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Also includes, Deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psycho-social well being. 2. Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance...(Examples: threats of harm, saying things to frighten a resident...4. Physical Abuse: Includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. 5. Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment of deprivation...Neglect: Failure to provide goods and services			

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	necessary to avoid physical harm, mental anguish, or mental illness...Abuse-Identification of...Procedure: 1. ...staff and supervisory personnel will be cognizant of the potential for abuse of residents...2. The Administrator will be responsible for monitoring quality assurance and quality improvement progress reports for patterns, occurrences and trends that would be suggestive of abuse, neglect, ...within the facility. 3. The Administrator will be responsible for monitoring incident/accident reports for potential abuse...Investigation...Procedure: ...3. Staff incidents which involve abuse, neglect, ...are investigated as follows: 3.1 The staff member is suspended immediately without pay pending investigation. It is the intent of the facility to finalize an investigation within 3-5 days...." The immediate jeopardy that began on 7/5/11 was removed on 7/15/11 when the facility suspended the staff accused of alleged abuse and began investigations, began immediate mandatory in-services on proper protocols to follow regarding abuse and neglect, reviewed facility's abuse policy and procedure and found it to be reasonable and accurate, met with all management staff and on-call nursing staff to review protocol for reporting			

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	abuse, revised the daily stand-up meeting form to include allegations of abuse and neglect, notified the facility Medical Director of the immediate jeopardy, posted phone numbers of the Administrator and Director of Nursing in multiple locations of the facility with instructions to immediately report any allegation of abuse at any time, ensured the Administrator or her designee will monitor abuse protocol by randomly interviewing five residents per week for no less than six months, and ensured the facility will continue to provide abuse and neglect education upon hire and at least twice annually, but the noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure staff continued to recognize and report abuse and monitor staff to ensure they continued to follow the corrective action plan. This Federal tag relates to complaint IN 00093132. 3.1-28(a)			
F0490 SS=L	A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.			

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	Based on interview and record review, the Administrative Staff failed to ensure Residents in the facility were protected from physical and verbal abuse by failing to follow their policy and procedures for reporting, investigating, monitoring, and documenting related to failure to suspend accused staff, investigate and document abuse allegations, and monitor for patterns and occurrences of alleged abuse for 2 of 4 residents (Resident: #B, #D) in the sample of 4 and 2 of 6 residents (Residents: #F, #G) in the supplemental sample of 6. This deficient practice had the potential to affect all 60 of 60 residents residing in the facility. The immediate jeopardy began on 7/05/11 when Resident # F, who was recovering from recent back surgery, reported to CNA #3 on 7/4/11 that CNA #2 had thrown her into bed and left her sideways in the bed. Resident # F then reported the incident on 7/5/11 to the Director of Nursing who failed to suspend CNA #2 and protect other residents from potential harm during investigation of the alleged abuse. The Administrator and the Director of Nursing (DON) were notified of the immediate jeopardy at 5:30 P.M. on 7/13/11. The immediate jeopardy was: removed on 7/15/11, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential	F0490	**F 490** Regarding Resident #B, CNA #8 was suspended on 5/4/11 after the facility became aware of the allegation. The CNA was terminated on 5/9/2011 following an investigation into the matter. This incident was reported to ISDH on 5/3/11. Regarding Resident #D, the facility has reviewed all grievances from this resident and/or family members and the facility alleges that this allegation was never reported to any member of administration at this facility. Resident #D has since been discharged from the facility. Because the facility was not aware of these allegations during her admission, an investigation into this alleged incident did not occur. Regarding Resident #F, the resident did not report to the facility that she had been thrown into bed. This allegation was not revealed to administration until the ISDH complaint surveyor interviewed the resident. As soon as the facility became aware of this allegation, CNA #2 was immediately suspended and an investigation was started. CNA #2 was terminated on 7/19/11. The surveyor was aware of this incident during the survey, and a follow-up report was sent to ISDH informing them of the facility's conclusion to the investigation on 7/19/11.	07/18/2011

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	for more than minimal harm that is not immediate jeopardy. Residents: #B, #C, #D, #F, #G Findings include: 1. A"Resident/Family Concern Report," dated 5/3/11, and signed by the Chaplain, indicated, "Nature of Concern: Resident (#B) reported rough handling and bad attitude of CNA #8 when resident asked repeatedly for bed pan last week. Resident #B thought she had asked 'someone in charge' to not have this CNA (#8) help with her care. Last evening, 5/2/11, (CNA #8) came to do (Resident #B's) shower. (Resident #8) reported she was sprayed in the face, and (CNA #8) was not following her wishes concerning (Resident #B's) clothing...." An "Investigation" report, dated 5/4/11 and signed by RN #9, indicated, "...The previous week Nurse (LPN #10) had called (Name), DON re: (regarding) a conflict between (Resident #B) and (CNA #8). (Resident #B) did not want (CNA #8) in her room. I was working Wing 200 that nite (sic) and overheard the phone conversation at the nurses station on Wed., April 27th." During interview with the DON on		Regarding Resident #G, CNA #8 was terminated on 5/9/11 and CNA #15 was terminated on 7/12/11. Mandatory in-services began immediately upon the facility becoming aware of the immediate jeopardy citation on 7/13/11. All staff members were educated before the beginning of their next shift on: the proper protocol to report abuse, what types of things to report, and what to do if the report is not followed up on. Staff members were instructed to notify the Administrator, or designee in the Administrator's absence, immediately upon becoming aware of any abuse allegation. In-services for all staff were completed by 7/18/11. (Attachment A) Management and on-call nursing staff were in-serviced on 7/14/11 to review proper protocol for reporting abuse. (Included in Attachment A) The facility Administrator reviewed the facility's policies and procedures regarding abuse and neglect on 7/13/11. They were found to be reasonable and accurate. However, after further review, minor modifications were made to the policy, "Abuse- Identification of and Protection of the Resident" to simplify the language and the procedure for staff members. (Attachment B)	

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	7/12/11 at 2:30 P.M., she indicated she was unaware Resident #B requested CNA #8 not be assigned to provide her care. Review of CNA's Personnel File on 7/11/11 at 3:20 P.M. lacked documentation of an investigation, a State reportable, counseling, or disciplinary action regarding the issue reported by LPN #10 regarding Resident #B's accusation of alleged rough handling by CNA #8 when assisting her with the bedpan (4/27/11). 2. During interview with Resident #D's daughter on 7/11/11 at 2:15 P.M., she indicated her mother had told her that a night CNA cussed at her, threw her in bed, and told her "I'm tired of you using that d--n call light. I'm tired of coming into your room. "My mother complained 'They're mean to me. They're mean to me.' I, at first, thought my mother was imagining it, but when the bruises and tremors were evident, I went to the DON with my concerns. I told her mother described the CNA as being a (race stated), tall woman. The DON said, 'We don't have a tall (race stated) girl working here.' My mother was lying in bed and looking up at the individual which probably made her look tall." In a second interview with Resident #D's		The facility Medical Director was notified of the immediate jeopardy citation on 7/14/11. The phone numbers of the Administrator and Director of Nursing were posted in multiple locations on 7/14/11 in order for any staff member to directly notify administration of any allegations of abuse, at any time. The form used as a guide for discussion in daily stand-up meeting was revised on 7/14/11 to include the statement, “Allegations of abuse or neglect?” (Attachment C) In order to ensure all staff are educated on abuse and neglect on an ongoing basis, the facility will continue to provide education on this subject upon hire and at least twice annually. In order to monitor and ensure that abuse policies are followed, the Administrator or her designee, will randomly interview five residents per week for a time period of no less than six months as to how staff members have been treating them. Any concerns will be thoroughly investigated. (Attachment D) Results of the monitoring program will be reviewed at the monthly CQI (Continuous Quality Improvement) meeting. Areas of non-compliance	

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	daughter on 7/12/11 at 9:20 A.M., she indicated she asked her mother if she could remember the name of the CNA who was rough with her. "It was a (race stated) girl in the middle of the night." "She did complain to the DON (Name) about the treatment. We were very upset when the bruises were discovered at the hospital. Mother remembers them shoving her around and slamming her into bed and she told them, 'Be careful your going to break my hip, again.' " During interview with the DON on 7/12/11 at 10:35 A.M., she indicated she was able to validate with the resident that the CNA was just hurrying. She further indicated, as a result, she did not feel there was a need to do a State Reportable. The Nursing staff schedule was reviewed and indicated CNA #15 was the only (race stated) CNA who provided care to Resident #D on the night shift. The May and June, 2011 schedules indicated CNA was assigned to provide care to Resident #D on the following dates: 5/24, 5/31, 6/7, 6/14, 6/18, and 6/19/11. CNA #15's Personnel File was reviewed on 7/12/11 at 4:15 P.M. and lacked documentation or any proof of investigation regarding Resident #D or her family's alleged abuse by CNA #15.		will be addressed immediately. Alleged date of compliance is 7/18/2011.	

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	3. During interview with Resident #F on 7/13/11 at 9:15 A.M., she indicated that about 2 weeks ago, CNA #2 came into her room to assist her to the bathroom. CNA #2 insisted on putting Resident #F's back-brace on while she was sitting down. Resident #F told CNA #2 that Physical Therapist #6 told her she should be standing when the brace is put on her. CNA #2 responded, "I'll do it my way." Resident #F let her put the brace on while sitting because she was desperate to get to the bathroom. When she finished in the bathroom, CNA #2 assisted her to her bed. Resident #F, again, confronted CNA #2, this time regarding the position of the side rail on the bed. Resident #F informed CNA #2 that Physical Therapist #6 taught her to get into bed with the side rail down so she could position her body up higher on the mattress. CNA #2 replied in a snotty manner, "I'm not the therapist." Resident #F indicated she was sitting on the side of the bed when CNA #2 grabbed her by the sleeve and pulled her down toward the foot of the bed. "She then pushed my shoulders down on the bed, threw the pillow from my w/c onto the bed along with a sheet I used to cover my lap, and left me there. When she got angry her face got as red as an apple. I was afraid my back would get injured. I just had surgery and I don't want to have gone			

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	through all that pain for nothing. I'm just beginning to recover." Resident #F indicated she could not get anyone to help her, but when she saw CNA #3 outside her room she waved to her and she came to offer assistance. "She said, Oh dear, what happened to you? I told her what CNA #2 had done to me." Resident #F indicated CNA #3 had a physical condition which restricted her ability to lift, but together they managed to get her up in the bed. "She rescued me." When queried about the incident and what Resident #F was feeling at the time, she indicated she was fearful of CNA #2. .Resident #F indicated CNA #2 no longer provided her care, "I feel better that she isn't near me, but I would feel better if I didn't have to see her." Resident #F indicated she told the Director of Nursing (DON) the next day about CNA #2 and how she had frightened her. She indicated the DON was shocked and stated she had never had any problems with CNA #2 in the past. "She told me CNA #2 would not be assigned to take care of me again." She further indicated the DON told her if she filed a report there could be legal ramifications as a result. The DON indicated in an interview on 7/13/11 at 11:00 A.M. that she had not suspended CNA #2 because Resident #F did not mention to her that CNA #2 threw			

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	her into bed, but that she was bossy and put her into the bed and left her feet hanging off the bed. "Forty-five minutes later, when I sought clarification, Resident #F told me her feet were on the bed and she used her foot to get her call light." The DON further indicated CNA #2 was one of her best workers. During a telephone conversation on 7/13/11 at 2:50 P.M. with CNA #3, while in the presence of the DON and with the "speaker phone" on, CNA #3 indicated she found Resident #F sideways in her bed. She further indicated Resident #F told her CNA #2 "threw her into bed and left her there." CNA #3 and LPN #7 failed to report the incident to the DON, but Resident #F had voiced mistreatment to her on 7/5/11. Resident #F's clinical record lacked documentation of an investigation, a State Reportable, counseling, or disciplinary action regarding the issue reported to the DON on 7/5/11 by Resident #F. 4. During interview with Resident #G on 7/13/11 at 10:35 A.M., she indicated she was fearful of using her call light because she had been yelled at by a staff person for having to go to the bathroom so much. "She would get angry when I had to go the			

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	155684	A. BUILDING 00 B. WING	07/15/2011

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	bathroom. She was yelling 'Ever since they removed the catheter you've been a problem.' When someone knocks, I jump. I told them I was sorry, but I couldn't help it. Every time this need comes up (to use the bathroom) I get frightened. Recently, I had my light on, but no one came. I hurt because the pressure was so great. I took my blanket and folded it into a square and tucked it under me so I could pee on it without getting the rest of my bed wet. I reported that to (Social Service Staff #5) and the DON. Review of an "Internal Investigation" report, dated 4/15/11, indicated, "Date of Occurrence: 4/2/11? or 4/3/11 Saturday night. Description of Occurrence: (Resident #G) c/o (complained of) a staff member complaining that she wants to go to the bathroom a lot and that her hands hurt after she grabbed her by the hands to take her into the bathroom...." A "Resident Statement" report, dated 4/4/11, indicated, "Sometimes I have vision and I can see...I think it was during the night or late evening. It was all about me having to go to the bathroom. This person was saying that I need to go to the bathroom all of the time. There was a time when I was. She said I had a problem. She was angry kind of. She said we need to do something about it...My hands are tender and she took me by the hands to take into the			

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	bathroom. They are sore...." A written statement by RN # 11, undated, indicated, "At 12 A (12:00 A.M.) 4/3/11, (Resident #G) began to tell me of an incident that she said happened last night. Attempted to clarify the time frame, but she was unsure. I gathered enough information to call in the morning to on call Supervisor. 7:45 A. M.-When I called LPN #12 (Supervisor), she called DON (Name) and requested a full statement and body check. Resident asked to tell what happened as it occurred. Resident (#G) didn't remember putting on call light, but someone came in, (Resident #G) said yelling at her. The following are statement contents and what she remembers. "You go (urinate) more than anyone I know." Resident (#G) said she needed to go to the bathroom. "I know this is all about going pee"...Someone grabbed her hands and was rough moving her around. "You need to do something about your bladder. You need to get your bladder checked. There is something wrong with you." Resident (#G) replied, "That may be true. (Resident #G) used the word 'forceful.' The person kept talking throughout the event to the bathroom and back. (Resident #G) said her face felt hot, and she was shaking all over...she said her hands hurt when they grabbed them...."			

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The "Internal Investigation" further indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and wrists...." Report "Conclusion: (Resident #G) suffers from confusion. Statements from staff are providing nothing conclusive. Her son seems to think that she is repeating an old idea...."

A "Resident/Family Concern Report," dated 4/18/11 and signed by the DON, indicated, "Concerning Resident #G Nature of Concern: This writer noted resident coming down the hall in her wheelchair being pushed by (CNA #13), I asked (Resident #G) how she was doing. She said, 'Not very good right now.' Upon further questioning she complained that one of the CNA's complained that she was 'peeing' too much....I questioned (CNA #8), the other CNA in her room this afternoon. (CNA #8) said 'I didn't say that, I just took her to the bathroom." Explained to CNA (#8) that resident's many times have (sic) to urinate frequently for different reasons and that we can't judge this. We merely take them to the bathroom...Resolution and Disposition: "...CNA apologized to

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	resident. A letter to the Indiana State Department of Health, dated 5/9/11, which included the Incident Report (regarding CNA #8 and another accusation by Resident #B) indicated, "...(CNA #8) was also involved on 4/18/11 in a complaint made by another resident, (Resident #G). She indicated that two CNA's complained that she urinated too frequently. One of these CNA's was (CNA #8)...." Resident #G's clinical record and the Personnel File of CNA #8, lacked documentation that the 4/2/11 and the 4/18/11 complaint of alleged abuse by Resident #G were reported to State authorities. During an interview with the Administrator on 4/14/11 at 4:00 P.M., she indicated she was unaware of the abuse allegations. "The Director of Nursing has always addressed those issues. The previous DON did the same thing." Review of a facility policy titled "Primary Abuse Prohibition Policy," dated 9/2000, indicated, "Policy: It shall be the policy of Southfield Village that all residents of this facility are free from verbal, sexual, physical, and mental abuse, corporal			

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	punishment and involuntary seclusion...The Administrator will be responsible for monitoring quality assurance and quality improvement progress reports for patterns, occurrences and trends that would be suggestive of abuse, neglect, ...within the facility. 3. The Administrator will be responsible for monitoring incident/accident reports for potential abuse...Investigation...Procedure: ...3. Staff incidents which involve abuse, neglect, ...are investigated as follows: 3.1 The staff member is suspended immediately without pay pending investigation. It is the intent of the facility to finalize an investigation within 3-5 days...." The immediate jeopardy that began on 7/5/11 was removed on 7/15/11 when the facility suspended the staff accused of alleged abuse and began investigations, began immediate mandatory in-services on proper protocols to follow regarding abuse and neglect, reviewed facility's abuse policy and procedure and found it to be reasonable and accurate, met with all management staff and on-call nursing staff to review protocol for reporting abuse, revised the daily stand-up meeting form to include allegations of abuse and neglect, notified the facility Medical Director of the immediate jeopardy,			

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	posted phone numbers of the Administrator and Director of Nursing in multiple locations of the facility with instructions to immediately report any allegation of abuse at any time, ensured the Administrator or her designee will monitor abuse protocol by randomly interviewing five residents per week for no less than six months, and ensured the facility will continue to provide abuse and neglect education upon hire and at least twice annually, but the noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure staff continued to recognize and report abuse and monitor staff to ensure they continued to follow the corrective action plan. This Federal tag relates to complaint IN 00093132. 3.1-13(a)			